DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 3 — 0 0 5

2. STATE: IOWA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
MAY 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.332

7. FEDERAL BUDGET IMPACT:
a. FFY 03 $ 1,284
b. FFY 04 $ 2,826

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Supplement 1 to Attachment 4.19B, pgs 2 & 3; and Attachment 4.19C, pg 1, 2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Supplement 1 to Attachment 4.19B, pg2; and Attachment 4.19C, pg 1

Approved: 03/03/04
effective: 05/01/03

Iowa 03-005
Approved: 03/03/04
effective: 05/01/03

10. SUBJECT OF AMENDMENT:
Reduces bed-hold payments and provides for reimbursement of Medicare coinsurances and deductibles only when actual Medicare payments are less than the Medicaid allowed amount.

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Kevin W. Concannon by sgv

13. TYPED NAME:
Kevin W. Concannon

14. TITLE:
Director

15. DATE SUBMITTED:
7/1/03 (faxed on 6/30/03)

16. RETURN TO:
Director
Iowa Department of Human Services
Hoover State Office Building
Des Moines, IA 50319

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 6/30/03

18. DATE APPROVED: MAR 03 2004

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: MAY 01 2003

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Thomas Scully

22. TITLE: Associate Regional Administrator for Medicaid

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Iowa

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

QMBs:	Part A SP	Deductibles	SP Coinsurance
	Part B SP	Deductibles	SP Coinsurance
Other Medicaid Recipients	Part A SP	Deductibles	SP Coinsurance
	Part B SP	Deductibles	SP Coinsurance
Dual Eligible (QMB Plus)	Part A SP	Deductibles	SP Coinsurance
	Part B SP	Deductibles	SP Coinsurance

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Iowa

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Special Rate Method

1. For nursing facility services covered under Medicare Part A, payments are limited to State plan rates and payments according to the following method:

(a) If the Medicare payment amount for a claim exceeds or equals the State plan rate or payment for that claim, Medicaid reimbursement will be zero (0).

(b) If the State plan rates and payments for a claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement is the lesser of:

(i) the difference between the Medicaid State plan rates and payments minus the Medicare payment amount; or
(ii) the Medicare coinsurance and deductible, if any, for the claim.

This paragraph does not apply to Medicare-certified hospital-based nursing facilities.

2. For services not listed in paragraph 1 above, Medicaid payments will be made up to the full Medicare coinsurance and deductible, if any, for the claim.

PAYMENTS FOR RESERVE BEDS

Payment is made for reserving beds in care facilities for residents during their temporary absence for the purpose indicated below when this is included in the resident's plan of care. No payment for reserved beds is made to hospitals.

Nursing Facilities

1. For periods of hospitalization for acute conditions: Up to 10 days per calendar month.

2. For leaves of absence for purposes of vacation or visits: Up to 18 days per year. Additional days will be allowed based on a physician's recommendation that additional days would be rehabilitative.

Payment for periods when a resident is absent for visits or hospitalization is made at 42% of the actual per diem rate, but not to exceed the maximum rate.

Out-of-state facilities are reimbursed at 42% of the Iowa payment to the facility.

Intermediate Care Facilities for the Mentally Retarded

1. For periods of hospitalization for acute conditions: Up to 10 days per calendar month.

2. For leaves of absence for purposes of vacation or visits: Up to 30 days per year. Additional days may be approved for home visits or special programs of evaluation, treatment or habilitation outside the facility if certified by a physician or qualified mental retardation professional.

Payment for period when a resident is absent for visits or hospitalization is made at 80% of the actual per diem rate. Facilities with 15 or fewer beds are reimbursed at 95% of the actual per diem rate.

Out-of-state facilities are reimbursed at 80% of the Iowa payment to the facility. Out-of-state facilities with 15 or fewer beds are reimbursed at 95% of the Iowa payment to the facility.

PAYMENTS FOR RESERVE BEDS (Cont.)

Facilities That Provide Skilled Nursing

1. For period of hospitalization for acute conditions: Up to 10 days per hospitalization per calendar month, not to exceed 10 days for any hospital stay whether or not the stay extends into a succeeding month or months. Prior approval from the Department is required before the facility submits its claim.

2. For periods of visits for participation in special social or rehabilitation programs: Up to 10 consecutive calendar days at a time with a maximum of 18 days in a calendar year. These must be approved in advance by the Department and are approved when (1) the resident or representative chooses to have the resident leave for this purpose, and (2) the family members or agency responsible for providing the alternative care can and will provide the care and make no charge to the Department for the care, and (3) the absence is approved in the physician's plan of care, and (4) the facility provides the usual medical equipment and supplies needed by the resident.

Payment for approved absence shall be made at 42% of the regular Medicaid rate.

Out-of-state facilities are subject to the limits in their state.

Psychiatric Institutions for Children

1. For periods of hospitalization for acute conditions: Up to 10 days per hospitalization per calendar month, not to exceed 10 days for any hospital stay whether or not the stay extends into a succeeding month or months.

2. For leaves of absence for purposes of vacation or visits: Up to 30 days per year. Additional days may be allowed based on a service plan approved by the district administrator or the superintendent of the institution for children or that person's designee.

Payment for approved absence shall be made at the full Medicaid rate.